

# GENERAL INFORMATION

## Patient Information

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_  
State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone #: \_\_\_\_\_ Work #: \_\_\_\_\_ Cell #: \_\_\_\_\_  
Sex: Male Female Marital Status: S M D W Age: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_  
Emergency Contact Name: \_\_\_\_\_ Emergency Phone #: \_\_\_\_\_  
Are you currently receiving Home Health (HH) for any reason? Yes No  
*(If answer is NO and HH services are being provided, patient is responsible for any services not covered by ins.)*  
How did you hear about us? *(Please check all that apply)* Phone Book Doctor  
Friend Billboard(location): \_\_\_\_\_ or  
Other(description): \_\_\_\_\_

## Employer Information

Employer Name: \_\_\_\_\_ Employer Phone #: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Work Status: \_\_\_\_\_

## Injury Questions

Date of Injury: \_\_\_\_\_ Date of Surgery: \_\_\_\_\_  
How were you injured?: \_\_\_\_\_  
Is this injury:  
Employment Related? Yes No Injury from an Auto Accident?: Yes No  
Is an Attorney involved?: Yes No Claim or Case #: \_\_\_\_\_  
If YES, please provide Attorney Name: \_\_\_\_\_  
Attorney's Address and Phone #: \_\_\_\_\_

## Responsible Party

Guarantor for Account: \_\_\_\_\_ Social Security #: \_\_\_\_\_  
Guarantor's Address: \_\_\_\_\_ City: \_\_\_\_\_  
State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Guarantor Phone #: \_\_\_\_\_ Alternate Phone #: \_\_\_\_\_

## Insurance Information *(mark SAME if information was previously given)*

**Please give your insurance cards and ID to the front desk to make copies.**

Primary Insurance: \_\_\_\_\_ Insured's Name: \_\_\_\_\_  
Insured's DOB: \_\_\_\_\_ Insured's Social Security #: \_\_\_\_\_  
Secondary Insurance: \_\_\_\_\_ Insured's Name: \_\_\_\_\_  
Insured's DOB: \_\_\_\_\_ Insured's Social Security #: \_\_\_\_\_

I certify this information is true and correct to the best of my knowledge. I authorize payment of benefits to Precision Physical Therapy, PLLC. I acknowledge that I am ultimately responsible for payment of services received.

Signature of Patient or Guarantor if Patient is a Minor

Date